FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005637

Facility Name: St Joseph Nursing Home

Address: 401 Ninth Street (Number) Lacon (City) 61540 (Zip Code)

County: Marshall

Telephone Number: (309) 246-2175 **Fax #** (309) 246-3069

IDPA ID Number: 0005637

Date of Initial License for Current Owners: 5/7/65

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: H. Dwayne Richardson **Telephone Number:** (314) 453-9696

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Thomas E. Becher

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) H. Dwayne Richardson, Principal

(Firm Name & Address) The Weiss Group, 940 West Port Plaza, St. Louis, MO 63146

(Telephone) (314) 453-9696 Fax # (314)453-0289

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: Not Applicable

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,045	16,161	36	33,242	10
11	ICF/DD			(Pending)		11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,045	16,161	36	33,242	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.93%

D. How many bed-hold days during this year were paid by Public Aid? 16 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/7/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/99 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	268,279		19,493	287,772	(26,428)	261,344	(48,970)	212,374			1
2	Food Purchase		186,080		186,080	(17,089)	168,991	(40,892)	128,099			2
3	Housekeeping	106,642	12,160		118,802		118,802		118,802			3
4	Laundry	73,001		8,446	81,447		81,447	(6,196)	75,251			4
5	Heat and Other Utilities			148,800	148,800		148,800	(5,501)	143,299			5
6	Maintenance	55,911		21,304	77,215		77,215		77,215			6
7	Other (specify):*											7
8	**TOTAL General Services**	503,833	198,240	198,043	900,116	(43,517)	856,599	(101,559)	755,040			8
	B. Health Care and Programs											
9	Medical Director			4,621	4,621		4,621		4,621			9
10	Nursing and Medical Records	1,045,881	78,484	11,127	1,135,492		1,135,492		1,135,492			10
10a	Therapy											10a
11	Activities	78,620	6,513	785	85,918		85,918		85,918			11
12	Social Services	67,115	2,729	2,325	72,169		72,169		72,169			12
13	Nurse Aide Training	2,500			2,500	386	2,886		2,886			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,194,116	87,726	18,858	1,300,700	386	1,301,086		1,301,086			16
	C. General Administration											
17	Administrative	110,768			110,768		110,768		110,768			17
18	Directors Fees											18
19	Professional Services			30,441	30,441		30,441		30,441			19
20	Dues, Fees, Subscriptions & Promotions			31,577	31,577		31,577	(11,698)	19,879			20
21	Clerical & General Office Expenses	89,027	10,862	27,000	126,889		126,889	(8,433)	118,456			21
22	Employee Benefits & Payroll Taxes			388,828	388,828	66,319	455,147	(9,902)	445,245			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,200	11,200	(386)	10,814		10,814			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			39,287	39,287	(22,802)	16,485	(609)	15,876			26
27	Other (specify):*											27
28	**TOTAL General Administration**	199,795	10,862	528,333	738,990	43,131	782,121	(30,642)	751,479			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,897,744	296,828	745,234	2,939,806		2,939,806	(132,201)	2,807,605			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Joseph Nursing Home #0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			67,560	67,560		67,560	(10,278)	57,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(4,974)	(4,974)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							(600)	(600)			36
37	**TOTAL Ownership**			67,560	67,560		67,560	(15,852)	51,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			603	603		603		603			39
40	Barber and Beauty Shops		892	12,622	13,514		13,514		13,514			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,670	39,670		39,670		39,670			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		892	52,895	53,787		53,787		53,787			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,897,744	297,720	865,689	3,061,153		3,061,153	(148,053)	2,913,100			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,620)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,529)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,716)	30		9
10	Interest and Other Investment Income	(4,974)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,815)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(104,405)	various		15
16	Personal Expenses (Including Transportation)	(4,904)	21		16
17	Non-Care Related Fees	(792)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,698)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(600)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,053)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (148,053)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Joseph Nursing Home

ID# 00056337

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Nursing Home # 0005637 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,227)	0	0	0	0	0	0	0	0	0	0	(9,227)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,227)	0	0	0	0	0	0	0	0	0	0	(9,227)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,698)	0	0	0	0	0	0	0	0	0	0	(11,698)	20
21	Clerical & General Office Expenses	(8,433)	0	0	0	0	0	0	0	0	0	0	(8,433)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,131)	0	0	0	0	0	0	0	0	0	0	(20,131)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,358)	0	0	0	0	0	0	0	0	0	0	(29,358)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St Joseph Nursing Home** **# 0005637** **Report Period Beginning:** **7/1/99** **Ending:** **6/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(8,716)	0	0	0	0	0	0	0	0	0	0	(8,716)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,974)	0	0	0	0	0	0	0	0	0	0	(4,974)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,690)	0	0	0	0	0	0	0	0	0	0	(13,690)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(43,048)	0	0	0	0	0	0	0	0	0	0	(43,048)	45

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NOT APPLICABLE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First National		x	Building Improvement		10/5/96	$ 40,000	$		10.0100	$ None	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Daughters of St. Francis											6
7	of Assisi	x		Working Capital	None	Various	224,000	204,000		None	None	7
8	First National		x	Working Capital	None	10/6/96	88,500			9.2500	None	8
9	TOTAL Facility Related						$ 352,500	$ 204,000			$ None	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 352,500	$ 204,000			$ None	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Not applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Owned by Daughters			$	1
2	of St. Francis of Assisi	428,532	1965	25,700	2
3	TOTALS	428,532		$ 25,700	3

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1965	1965	$ 484,023	$ 10,532	VARIOUS	$ 7,935	$ (2,597)	$ 448,318	4
5	50		1969	1969	898,293	19,663	VARIOUS	15,034	(4,629)	827,870	5
6			1968	1968	451,401		25			451,401	6
7			1986	1986	3,877		12			3,877	7
8			1987	1987	5,840	389	15	389		4,865	8
	Improvement Type**										
9	MISC			1968	6,160		50			6,160	9
10	GARAGE			1972	2,491		50			2,491	10
11	FINISH BASEMENT			1973	6,343		50			6,343	11
12	WINDOW			1974	900		50			900	12
13	INSULATION			1976	21,986		50			21,896	13
14	ROOF			1980	16,049	402	50	321	(81)	16,049	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS			1982	1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS			1983	877		10			877	17
18	IDPA AUDIT ADJUSTMENTS			1984	53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS			1985	13,995	466	15	466		13,995	19
20	IDPA AUDIT ADJUSTMENTS			1969	28,119		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS			1977	11,869	222	50	222		5,470	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429	647	VARIOUS	647		92,024	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038	7,064	VARIOUS	4,197	(2,867)	96,225	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937	1,281	VARIOUS	1,281		16,929	25
26	FIRE ALARM SYSTEM			1990	37,956	1,886	VARIOUS	1,886		20,525	26
27	NEW ROOF			1992	55,787	5,578	10	5,578		47,418	27
28	HOT WATER TANK			1992	3,295	330	10	330		2,802	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434	43	10	43		325	30
31	WATER HEATER			1993	223	15	15	15		112	31
32	BOILER REPAIR			1993	1,415	141	10	141		1,061	32
33	CODE ALERT FIRE SYSTEM			1995	8,559	1,006	VARIOUS	1,006		4,707	33
34	MISC			1997	3,013	603	5	603		2,108	34
35	VINYL FLOOR			1998	4,012	802	5	802		1,203	35
36	TOTAL (lines 4 thru 35)				$ 2,400,685	$ 51,071		$ 40,897	$ (10,174)	$ 2,197,434	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IDPA AUDIT ADJUSTMENT			1985	1,335		10			1,335	9
10	CERAMIC FLOOR FOR NEW TUB			1999	107	5	20	5		8	10
11	CARPET ON WALLS			2000	2,668	267	5	267		267	11
12	METAMORA TELPHONE SYSTEM			2000	7,337	367	10	367		367	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,447	$ 639		$ 639	$	$ 1,977	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 133,675	$ 15,441	$ 15,337	$ (104)	VARIOUS	$ 61,472	37
38	Current Year Purchases	7,225	409	409		VARIOUS	409	38
39	Fully Depreciated Assets	412,826				VARIOUS	412,826	39
40								40
41	TOTALS	$ 553,726	$ 15,850	$ 15,746	$ (104)		$ 474,707	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	NURSING HOME	CHEVY CAPRICE	1987	$ 10,289	$	$	$		$ 10,289	42
43	NURSING HOME	PICKUP	1995	14,590					14,590	43
44	NURSING HOME	MISC. OTHER	VARIOUS	7,279					7,279	44
45										45
46	TOTALS			$ 32,158	$	$	$		$ 32,158	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,023,716	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 67,560	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 57,282	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (10,278)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,706,276	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	SISTERS SHARE OF BUILDING	$ 63,491	$ 1,562	$ 59,028	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 63,491	$ 1,562	$ 59,028	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WORKSHEET NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 83

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			136		136
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		2,500		2,500
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			250		250
9	TOTALS		$	$ 2,886	$	$ 2,886
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,886			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St Joseph Nursing Home # 0005637 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,390	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,642)	167,117		3
4	Supply Inventory (priced at cost)	22,889		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,239		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 272,635	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	76,103		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	190,022		15
16	Equipment, at Historical Cost	1,161,524		16
17	Accumulated Depreciation (book methods)	(2,260,418)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Board Designated Assets	151,275		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 860,881	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,133,516	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,266	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,390		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 162,656	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Motherhouse	204,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 204,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 366,656	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 766,860	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,133,516	$	48

***(See instructions.)**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 715,677	1
2	Restatements (describe):		2
3	**Prior year rounding difference noted**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 715,678	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,182	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 51,182	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 766,860	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,533,865	1
2	Discounts and Allowances for all Levels	(569,929)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,963,936	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	618	11
12	Gift and Coffee Shop	792	12
13	Barber and Beauty Care	17,242	13
14	Non-Patient Meals	6,620	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,544	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 33,816	23
	D. Non-Operating Revenue		
24	Contributions	20,042	24
25	Interest and Other Investment Income***	4,974	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,016	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SISTERS MAINTENANCE (ACCT. 781019)	88,967	28
28a	GAIN ON EQUIPMENT DISPOSAL	600	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 89,567	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,112,335	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	900,600	31
32	Health Care	1,264,441	32
33	General Administration	735,095	33
	B. Capital Expense		
34	Ownership	67,560	34
	C. Ancillary Expense		
35	Special Cost Centers	53,787	35
36	Provider Participation Fee	39,670	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,061,153	40
41	**Income before Income Taxes (line 30 minus line 40)****	51,182	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 51,182	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,200	2,264	$ 41,100	$ 18.15	1
2	Assistant Director of Nursing	1,560	1,600	27,104	16.94	2
3	Registered Nurses	13,026	14,166	220,138	15.54	3
4	Licensed Practical Nurses	8,089	8,927	118,605	13.29	4
5	Nurse Aides & Orderlies	60,685	65,630	510,580	7.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,320	5,963	66,788	11.20	8
9	Activity Director	2,056	2,080	17,376	8.35	9
10	Activity Assistants	6,646	7,383	61,193	8.29	10
11	Social Service Workers	4,725	5,029	52,362	10.41	11
12	Dietician					12
13	Food Service Supervisor	3,752	4,104	54,184	13.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,091	16,023	115,286	7.20	15
16	Dishwashers	13,555	14,702	98,807	6.72	16
17	Maintenance Workers	3,682	4,202	55,860	13.29	17
18	Housekeepers	13,890	15,473	106,642	6.89	18
19	Laundry	10,358	11,370	73,001	6.42	19
20	Administrator	2,000	2,080	72,090	34.66	20
21	Assistant Administrator	2,040	2,080	40,768	19.60	21
22	Other Administrative					22
23	Office Manager	736	752	11,222	14.92	23
24	Clerical	7,739	8,633	75,713	8.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,555	2,887	34,495	11.95	31
32	Other Health C: MDS	1,992	2,080	29,678	14.27	32
33	Other(specify) Priest Chapel	1,538	1,560	14,752	9.46	33
34	TOTAL (lines 1 - 33)	182,235	198,988	$ 1,897,744 *	$ 9.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	118	$ 4,837	1	35
36	Medical Director	2	200	19	36
37	Medical Records Consultant	48	1,718	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,025	10	39
40	Physical Therapy Consultant	93	4,663	10	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	1,341	10	43
44	Activity Consultant	17	1,410	11	44
45	Social Service Consultant	16	1,410	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	409	$ 16,604		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Becher	Adm.	0	$ 70,000
Martha Schlink	Asst. Adm.	0	40,768
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,768

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Software	Software	$ 4,697
Valuation Counselors	Depreciation Valuation	750
Computerland	Software	4,340
Clifton Gunderson	Accounting	6,848
The Weiss Group	Accounting	12,000
Accumeasure	Software	600
Champion	Payroll Software	499
Other	Various	707
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 30,441

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,802
Unemployment Compensation Insurance	
FICA Taxes	130,615
Employee Health Insurance	200,369
Employee Meals	43,517
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	48,936
EMPLOYEE BENEFITS	8,908
SISTERS MAINTENANCE	(9,902)
TOTAL (agree to Schedule V, line 22, col.8)	$ 445,245

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Not Applicable		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,698
Health Care Worker Background Check	
(Indicate # of checks performed 33)	396
Misc. Dues and Licenses	19,483
Less: Public Relations Expense	( )
Non-allowable advertising	(10,399)
Yellow page advertising	(1,299)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,879

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	1,041
Van Maintenance/Gas	672
Seminar Expense	9,487
NURSE AIDE TRAINING	(386)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,814

**See instructions.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	WORKSHEET NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Joseph Nursing Home # 0005637 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Catholic Hlth Assoc., AAHSA, Life Services Network, Lacon Chamber of Commerce**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,180** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **Not Applicable**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **39,670**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes-Sisters (no costs)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **43,517** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,620**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **Not Applicable**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **None**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Weiss, Burds and Company, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **Not Applicable**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Not Applicable**
Attach invoices and a summary of services for all architect and appraisal fees.

end